HIE Steering Committee

Claims Pilot Subcommittee

Meeting #6 – June 18, 2021

Agenda

- Review New Use Cases: Point of Care
- Next Steps

Role of Subcommittee Members Re: Use Cases

- Learn about each of the use cases presented by fellow subcommittee members
  - *What is the user trying to accomplish? How does this relate to or inform my use cases?*
- Weigh in: support editing, culling, prioritizing
  - *How could this be augmented to be clearer? Is it missing anything? Where does this fit in your sense of priorities?*
- Support assessment of technical feasibility by VITL and MMIS partners

Use Case Categories - Definition

- Clinical uses – Individual:
  - These use cases focus **on how data/information is used in a clinical setting to support clinical decisions** made **between an individual and their provider**.

- QI/operational - Organization:
  - These use cases focus **on how data is used by an organization** and can be grouped into two categories. 1) How a health care organization uses data **to improve its processes/workflow** and improve panel management for groups of patients. 2) How a program uses data **to enhance operations** such as setting payment levels for value-based payments or making policy decisions on how the program operates.

- Evaluation – Population health:
  - These use cases focus on whether a program, policy, or intervention achieved what it meant to achieve. The **outcomes are used to support decision making**; can be more dynamic and flexible that reporting, though often rely on similar nationally recognized measures; see below.

- Reporting – Population Health:
  - These use cases are **measures** often agreed upon at the beginning of a program/ agreement/demonstration **to be monitored by an overseeing entity**, e.g., the federal government. Generally, these **measures are drawn from nationally recognized measures**.

Use Case Review

Quality and Equity in Health Centers in Vermont

USER STORY

Actor(s): Blueprint QI Facilitator

As a Blueprint QI Facilitator,

I want to access to the linked Clinical & Claims Data in standardized format and look at the variations and stratify the data by provider and/or population,

So that I can identify:

- If best practices are implemented
- Opportunities for Quality Improvement (QI)

Using the linked Clinical & Claims Data, QI Facilitator can identify more targeted approach to meet the goals identified by the Practice for health outcomes, service utilization, and organizational processes and protocols.

Some of the measures (data) used by QI Facilitator to assess performance or apply as stratification metrics are:

a) Cancer screening
b) Developmental screening (children)
c) Building Bright Futures recommended performance standards.
d) Value based incentive measures
e) Depression screening
f) Suicide risk assessments (new challenge)
g) Patient experience
h) Health Care costs
i) Morphine Milligram Equivalents(MMEs) data for Opioid distribution
j) Duplication in medication
k) Referral costs

Aspects of Diversity: Zip Code, Race, Ethnicity, Age, Gender, by Payer, CQM (Clinical Quality Measures)

USE CASE: QI/Operations - Organization

Quality and Equity in Health Centers in Vermont

ORGANIZATIONS

1. Blueprint Facilitator Network exists to provide Patient Center Medical Home (PCMH) navigation, coach on Quality Improvement methods, connecting Organizations with available performance data, and using State and local Data to help motivate and evaluate other Public Health Interventions such as Community Health Profiles, Hub & Spoke Profiles, WHI – Women's Health Initiative Profiles.
2. Blueprint does not produce Claims Data, it uses the Claims Data, then reorganizes and repackages it.
3. Blueprint uses Claims Data to:
    a) Identify variations and opportunities for improvement.
    b) Understand the potential of equivalent organizations.
    c) Balancing measures.
    d) External validation of internal performance measures.

CHALLENGES/PAIN POINTS

Currently have access to -

1. Clinical Data:
    a) Has access to 18 months old data packaged by Blueprint.
    b) Anything out of Workbench One for Accountable Care Organization (ACO) participating Organizations and only for the ACO attributed population, through analytics platform supported by Local Provider/Organization
2. Claims Data:
    a) Has access through Workbench One.
    b) Through Bistate only for certain Payers and only for the Federally Qualified Health Centers (FQHC) i.e., members of Bistate
3. Integrated Clinical and Claims Data:
    a) Through Care Coordinator Registered Nurses(RN) when doing Care Plans to meet ACO deliverable targets as an ACO participant.(Through Care Navigators platform)

CHALLENGES/PAIN POINTS *(continued)*

Challenges/Pain Points:

a) EMR output formats are different for different organizations.
b) Validation of internal reporting to external data collection (ACO, State etc.)
c) For National Committee for Quality Assurance (NCQA), the ACO data based on current participation is not representative of at least 75% of the population served by the Health Care Organizations. Hence this data and information cannot be used to support PCMH recognition.
d) In general, Indexes (e.g., Resource Utilization Index (RUI) etc.) are not very well understood by Providers, Health Care Organizations, and everyone
e) A1C & Eye Exam (combo measure) is great for understanding how well the Organization is doing in comparison to peers in terms of providing the standard of Care, but they are not useful without individual measures to help guide resources and Quality Improvement (QI).
f) NCQA needs data that is not older than 12 months, because of the annual renewal cycle after the redesign in 2017

GOAL

1. External validation
2. Comparison to other health care sites
3. Identifying opportunities for Quality Improvement
4. Identifying gaps/disparities in Care
5. Identifying system/technical issues in relaying information from local Health Care Organizations to Payers, ACO and Vermont Health Information Exchange (VHIE)

All the above goals are applicable for using Clinical Data alone, as well as when linked to Claims Data.

TRADING PARTNERS AND SYSTEMS

1. **Systems:**
    a) Clinical Registry Data at VHIE
    b) Care Navigator Platform
    c) Workbench One
    d) Immunization Registry reporting
    e) EMR Systems of local organizations,
    f) Vermont Agency of Human Services (VAHS) Community Profiles
2. **Organizations/partners:**
    a) AHS
    b) ACO
    c) Immunization Programming Team
    d) Blueprint
    e) VHIE
    f) Bistate
    g) Analytics or Reporting Teams of individual EMR Vendors at Health Care Organization

USE CASE: QI/Operations - Organization

Quality and Equity in Health Centers in Vermont

DATA TO EXCHANGE

1. Clinical Quality Measure Data & performance
2. Claims Cost Data
3. Vaccination Rates
4. Patients with Care Plans
5. Distribution of Diseases
6. Aspects of Diversity
7. Variations of performance between different Sites of the same Organization
8. Eligibility information from Claims, specifically Medicaid
9. Identifying patients who will be eligible for supplemental program(s)
10. Access to legitimate Death Registry

FREQUENCY

1. Preferably not older than 12 months data, due to transition to annual reporting cycle for PCMHs
2. When using CQM data for Quality Improvement, frequency of extraction depends on CQM and the population under focus e.g., Quarterly for acute care needs patients Vs Annually for controlled measures patients.
3. Real Time data around ADT and Utilization through Patient Ping helps PCMH sites meet core requirements particularly CC14 (Care Coordination and Care Transitions) through 16

DATA GOVERNANCE

1.**Access Data:**

a) HIPAA
b) 42 CFR Part 2
c) ACO Participant Agreements
d) Facilitator Contract
e) Blueprint Grant for each Health Service Area (HAS)?
f) VHIE Opt-In/Out Agreements
g) ACO Attribution (Opt-In/Out)
h) Health and Human Services (HHS) Information Blocking (part of Office of National Coordinator - ONC)
i) Health Resources & Services Administration (HRSA) requirements for FQHC's

2. **Exchange Data:**

a) Immunization Medical Records (IMR) Data Sharing Rules

All the Data Governance rules mentioned for accessing Data are applicable for exchanging Data as well.

USE CASE TARGET DATE

As soon as its available

MMIS DATA PIPELINE

TBD with Technical Team

DATA FORMAT (Source to VHIE)

1. CSV or MS Excel
2. API
3. VHIE should be able to accept data from small PCMHs (Paper?)

TRANSPORT MECHANISM

Preferably in FHIR format.
TBD with Technical Team.

DATA RECIPIENT FORMAT (VHIE to End User)

1. CSV or MS Excel or HL7
2. VHIE should be able to provide data to small PCMHs in their preferred formats

CONSENT SPECIFICATIONS

1. VHIE Opt-In/Out Agreements
2. ACO Attribution (Opt-In/Out)

LEGAL AGREEMENTS

1. Agreements between Provider/Health Care Organization and VHIE

Discussion/Feedback

Debrief on Use Case Gathering Process

- What did you do to prepare?
- What helped you successfully participate in the process?
- What went well?
- What can be improved?
- What should others expect?

Use Cases Summary

	Category	Use Case Name	Stakeholder
1	Clinical - Individual	Prescription Reconciliation, Fulfillment Monitoring	Mary Kate Mohlman
2	Clinical - Individual	Validate the Service Provided	Mary Kate Mohlman
3	QI/Operations - Organization	Panel Management of Individuals with Chronic Conditions– identifying those whose conditions need better management	Mary Kate Mohlman
4	Evaluation - Population	Assessing Quality Improvement Initiatives on Hypertension Control and Outcomes	Mary Kate Mohlman
5	Reporting - Population	Percent of population with Hypertension in control and Diabetes in poor control	Mary Kate Mohlman
6	QI/Operations - Organization	Improving support and Care management for individuals with Hypertension and Diabetes in the State	Katelyn Muir
7	QI/Operations - Organization	Improve Immunization Rate	Katelyn Muir
8	Evaluation - Population	Evaluating the Clinical impact of the Care Coordination Model	Katelyn Muir
9	Evaluation - Population	Evaluation of primary prevention by Health Service Areas (HSA)	Katelyn Muir
10	QI/Operations – Organization	Determine payments made to providers participating in Medicaid value-based payment arrangements.	Pat Jones Erin Flynn
11	Reporting - Population	AHS/DVHA Payment Reform Alternative Payment Model Program Monitoring and Reporting	Pat Jones Erin Flynn

Use Cases Summary

	Category	Use Case Name	Stakeholder
12	Clinical – Individual	Help inform Care Management Functions	James Mauro
13	QI/Operations – Organization	Identify Members for Integrated Health Programming including Risk Stratification	James Mauro
14	Evaluation - Population	Evaluate the performance of a Healthcare Reform/Payment Reform Program	James Mauro
15	QI/Operations – Organization	Development of a Healthcare Reform/Payment Reform Program	James Mauro
16	Reporting - Population	Conduct quality reporting that requires clinical data without relying on manual medical chart extractions	James Mauro
17	QI/Operations – Organization	Clinical data to support Utilization Management Program	James Mauro
18	QI/Operations - Organization	Defining more precise scope of a Health Care Organization (e.g., Provider landscape)	Sarah Lindberg
19	Evaluation - Population	Evaluation of Provider Quality	Sarah Lindberg
20	QI/Operations - Organization	Quality and Equity in Health Centers in Vermont	Thomasena E Coates

Next Steps

- Prioritize the use cases
- Evaluate the subcommittee's work and identify remaining gaps
- 1 or 2 more sessions for Bi-State/VAHHS/Medicaid Teams' Use Cases

Use Case Gathering Sessions

#	Interview	Focus of Discussion	Schedule & Status
1	**Katie Muir**, *OneCare VT*	• Evaluation & Reporting of the APM • Support of clinical practices and the care model	**3/3/2021 – Completed**
2	**Pat Jones**, *DVHA Payment Reform* **Erin Flynn**, *DVHA Payment Reform*	• Evaluation & Reporting of the APM • Support of clinical practices and the care model	**3/30/2021 – Completed**
3	**Ben Green**, *Blue Cross Blue Shield* **James Mauro**, *Blue Cross Blue Shield*	• Commercial Claims	**4/19/2021 – Completed**

4	**Sarah Lindberg**, *Green Mountain Care Board*	• Analytics for -
		  • evaluating the APM
		  • evaluating the Boards regulatory activities
			5/10/2021 – Completed

5	~~**Emma Harrigan**, *VAHHS*~~ **Lauri Scharf**, *BiState Primary Care Assoc.* **Thomasena E Coates**, *Blueprint QI Facilitator*	• Point of care support	**6/1/2021 – Completed**
6	**Lisa Schilling**, *Medicaid Operation* **Erin Carmichael**, *Medicaid Quality* **Shawn Skaflestad**, *Medicaid Performance Management/Improvement* **Tim Tremblay**, *Vermont Blueprint for Health*	• Quality Improvement and Reporting for Medicaid and the Blueprint • Overall evaluation of GC1115 waiver	**6/10/2021 – Completed**